

Prescription Drug Generic Rebate and Dispensing Cost Study Proviso

Executive Summary: Generic Rebate and Dispensing Cost Studies

Increasing the State's purchasing power was a key factor in creating the Kansas Health Policy Authority by combining health purchasing under its purview. This includes pharmaceuticals purchasing in the Medicaid program. After reviewing rebates for Kansas Medicaid, analyzing available dispensing cost surveys, and a thoughtful review of current pharmacy reimbursement practices both nationally and locally, the agency recommends no changes to the current system at this time. However, the KHPA recommends the following for the Kansas Medicaid program:

- Monitor rebate levels for brand-name and generic drugs to ensure compliance with Federal law.
- Monitor the impact of Part D on supplemental rebates,
- Track savings and rebates on recently available high volume/high cost generic medications and study the potential of supplemental rebates on those drugs.
- Determine impact of Federal pricing changes on Medicaid reimbursement.
- Determine impact of national changes to published prescription drug pricing, including but not limited to AWP and AMP.
- Monitor impact of Medication Therapy Management Services (MTMS) programs on quality of care in both Medicare and Medicaid programs for potential changes to Kansas Medicaid.
- Pilot MTMS in Kansas Medicaid, funded by CMS transformation grant. If not funded by CMS transformation grant, consider funding through Kansas Medicaid with federal matching funds.
- Bring together pharmacy stakeholders to gather information and evaluate the impact of pharmacy pricing changes on reimbursement methodologies and access, especially in rural counties.
- Study the impact of e-prescribing on dispensing costs and quality of care and the feasibility of implementing e-prescribing in Kansas Medicaid.
- Pilot e-prescribing in Kansas Medicaid, funded by CMS transformation grant. If not funded by CMS transformation grant, investigate integrating into the MMIS and obtaining 90 percent federal match rate to develop.

Introduction:

The Kansas Health Policy Authority (KHPA) is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. By statute, all health insurance purchasing by the State is now combined under the Authority, including publicly funded programs such as Medicaid, State Children's Health Insurance Program and MediKan and the State Employee Health Benefits Plan (SEHBP).

Purchasing power is critical to the vitality of the agency and its overall mission of improving quality and accessibility of healthcare to Kansans. By consolidating all health purchasing under the Authority's purview, it maximizes the purchasing power the State and KHPA has and can greatly benefit the people of Kansas.

As outlined in proviso, the 2006 Kansas Legislature requested the agency to study generic drug rebates and the cost of dispensing medication. Specifically, the proviso requested the KHPA:

"...study rebates for the state pharmaceutical purchasing plan, including the possibility of increasing rebates for generic products, in light of the consolidation of state purchasing under the Kansas health policy authority: *Provided*, That the Kansas health policy authority shall conduct a survey of Kansas retail community pharmacies or utilize a recently conducted national survey of a statistically relevant sample of pharmacies, to determine the cost of dispensing pharmaceutical products and services within the Kansas medicaid program: *Provided further*, That such study shall be conducted on or before September 30, 2006: *And provided further*, That the Kansas health policy authority shall present the cost of dispensing survey, analysis and recommendations of the Kansas health policy authority to the joint committee on health policy oversight on or before November 30, 2006."

For the past several months, the Kansas Health Policy Authority has examined its current pharmaceutical purchasing plan for Kansas, prescription drug reimbursement issues at the national level, and the direction for the future. Although the KHPA recommends the Medicaid prescription drug purchasing plan to remain unchanged for now, it is important that we continue to closely monitor rebate levels for both brand name and generic prescriptions; monitor the impact of Medicare Part D on rebates and pharmacy reimbursement; track savings and rebates on high volume/high cost generic medications; and evaluate the impact of e-prescribing and MTMS on quality care and expenditures. These recommendations are based on an analysis of Kansas Medicaid pharmacy rebates; regional and national dispensing cost surveys; current pharmacy reimbursement practices; and Kansas Medicaid and HealthConnect current pharmacy reimbursement methodology.

Pharmacy Rebate Study

State Medicaid programs are required by Federal law to cover medications that are rebated by the pharmaceutical manufacturer, with the exception of a few drug categories (for example, OTCs, weight-loss drugs, cosmetic drugs, benzodiazepines). Rebates differ for brand-name and generic drugs. Manufacturers of brand-name drugs are required to provide a minimum rebate of 15.1 percent of average manufacturer's price (AMP). Generic manufacturers are required to provide a minimum 11 percent rebate on AMP.

Kansas Medicaid spent \$251,543,689 in fiscal year 2006 on prescription drugs. During that time period, the program recouped over \$74 million in rebates. The following table

illustrates the amount of volume and expenditures that brand-name and generic medications account for.

Kansas Medicaid Fiscal Year 2006 Pharmacy Expenditures

	Volume	Expenditures	Avg Cost/Rx	Rebates	Avg Rx Cost Net Rebate
Brand- Name	1,766,326	\$206,722,264	\$117.04	\$73,069,420	\$75.67
Generic	2,605,675	\$44,821,425	\$17.20	\$1,325,052	\$16.69
TOTAL	4,372,001	\$251,543,689	\$57.54	\$74,394,472	\$40.52

An analysis rebates showed that Kansas is recouping, on average 29.5 percent of total expenditures in prescription rebates. A more detailed study of generic rebates showed that Kansas Medicaid is recouping 3 percent of average prescription cost on generic pharmaceuticals, and over 35 percent of average cost on brand-name pharmaceuticals, but the cost difference between brand-name and generics is almost ten-fold.

In addition to the rebate amount required by Federal law, Kansas Medicaid obtains supplemental rebates from manufacturers for inclusion on the preferred drug list (PDL) as long as the drugs in that category have been determined to be clinically equivalent by the PDL panel of physicians and pharmacists. To date, Kansas Medicaid obtained a very small amount of supplemental rebates from generic manufacturers. Generics with multiple manufacturers typically cost much less than their brand-name counterparts, as seen in the previous table (\$117.04 brand-name vs \$ 17.20 generics) and have a much smaller profit margin. However, in the past year a number of “blockbuster” drugs with very high utilization have become available generically, including Zocor and Zoloft. It may be useful for the KHPA to investigate the potential of obtaining supplemental rebates on these drugs. This should be undertaken cautiously and the impact on market competition evaluated.

The Medicare Part D program has resulted in a drop in prescription volume and expenditures paid for through Medicaid of approximately 40 percent. A corresponding drop in rebates has occurred as well. FY 2007 will be the first full fiscal year without prescription drug expenditures for Medicare-eligible individuals.

Generic Rebate Policy Recommendations

- Monitor rebate levels for brand-name and generic drugs to ensure compliance with Federal law.
- Monitor the impact of Part D on supplemental rebates,
- Track savings and rebates on recently available high volume/high cost generic medications and study the potential of supplemental rebates on those drugs.

Dispensing Cost Study

Reimbursement of prescription drugs consists of two components: 1) average wholesale price (AWP) less a percentage and 2) dispensing fee. It is well known in the industry that AWP is not reflective of actual pharmaceutical costs, thus the practice of reimbursing an

amount discounted from AWP. This methodology is unique to pharmacy, is consistent across all payers, public and private, and has been in place for many decades.

Kansas Medicaid currently reimburses pharmacy providers AWP – 13% for brand-name drugs, and AWP – 27%, the Federal Upper Limit (FUL) or State Maximum Allowable Cost (MAC) for generics, plus a \$3.40 dispensing fee per prescription.

In order to determine the cost of dispensing pharmaceutical products and services in the Medicaid program, KHPA staff obtained several recently conducted state and national dispensing surveys, and conducted an informal polling of local Kansas pharmacies. Those surveys are summarized below.

State-Level Dispensing Cost Surveys

- Oklahoma- the University of Oklahoma College of Pharmacy conducted a survey on behalf of the Oklahoma Health Care Authority using 2002 prescription claims and pharmacy operational cost data. Dispensing costs were calculated using pharmacy overhead and labor costs only. The survey concluded that the average dispensing cost in Oklahoma \$8.01 per prescription.
- Indiana- Myers and Stauffer, a Topeka, Kansas based firm, conducted a dispensing survey for the Indiana Office of Medicaid Policy and Planning using prescription claims paid between July 1, 2003 and June 30, 2004 and comparative data from other state Medicaid agencies. Myers & Stauffer evaluated operational, professional services, overhead and profit data relating to the costs of pharmacy operations. Based on this survey, it was concluded that Indiana's statewide average cost of dispensing was \$7.95 per prescription.

National Dispensing Cost Surveys

- The Center for Pharmacoeconomic Studies, University of Texas at Austin conducted a survey of fifty (50) national and regional chain pharmacies to estimate costs of dispensing a prescription. The survey included an evaluation of pharmacy financial and operational data. Calculated dispensing costs ranged from \$8.85 to \$10.39 per prescription, with a mean of \$9.61 per prescription. The study conclusion indicates more widespread studies are needed and clarified that the sampling method for this study was not random nor were the estimates of cost to dispense exclusive to Medicaid prescriptions.
- The National Community Pharmacists Association (NCPA), using 2005 Pfizer Digest Data, determined dispensing costs range from \$7.84 to \$9.24. NCPA also estimated dispensing costs by geographic region. The West Central region, in which Kansas was included, was determined to have a dispensing cost of \$9.05.
- The National Association of Chain Drug Stores (NACDS) is currently conducting a dispensing cost survey. Publication is slated for late November / early December 2006.

While this proviso referred only to dispensing fee costs, it is important to consider total prescription drug reimbursement and impending changes at the national level that will impact pharmacy reimbursement by all plans, including Medicaid. There are two major changes related to published pricing that have been imposed to address the long-standing problem of AWP not being representative of actual cost.

The first are changes made at the federal level regarding prescription drug price setting for generics. The second has to do with a drug pricing publisher widely used to set pricing.

The Federal Deficit Reduction Act (DRA) of 2005 changes how federal upper limit (FUL) pricing is calculated for generic drugs. The DRA changes FUL pricing from 150 percent of the lowest published AWP price to 250% of Average Manufacturer Price (AMP). This will lower generic reimbursement to pharmacies and will significantly increase the number of generics subject to FUL reimbursement. Beginning July 2006, the DRA also required that CMS provide State Medicaid agencies with the AMP of all rebated pharmaceuticals. States have been instructed by CMS not to use the AMP data to set reimbursement. AMP has historically been reported to CMS by pharmaceutical manufacturers and is not transparent to consumers.

The second major change is in regard to pricing published by a major drug data provider. Recently, First Databank, one of two major providers of drug information and cost data, was sued for using practices that resulted in inflating AWP. FDB settled the lawsuit in October 2006 and agreed that two years after the settlement they would no longer publish AWP.

The pharmacy community is concerned that the lower AMP will eventually become the benchmark price payers will use to set their reimbursement rates, as opposed to AWP, and that it too will not be reflective of actual costs.

Another major issue affecting reimbursement is the recent change enabled by the Part D legislation that allows Medicare prescription drug plans to reimburse clinicians, including pharmacists, for medication therapy management services (MTMS). This is a welcome change to the pharmacy community, who for years has advocated the impact of pharmacists' professional services on improving quality of care for their patients. Many Medicaid programs are beginning to follow suit and reimburse pharmacists for MTMS. Kansas Medicaid recently applied for a CMS transformation grant to pilot a MTMS program.

Lastly, e-prescribing is gaining adoption throughout the country as a means to reduce medication errors, improve quality of care and reduce administrative inefficiencies in handling prescriptions. The impact of e-prescribing on dispensing costs should be measured before changes to reimbursement are made. Kansas Medicaid applied for two e-prescribing grants through the CMS transformation grant program. CMS has announced that awards will be made in December 2006.

Due to the confluence of events surrounding pharmacy reimbursement at the national level, the impact of e-prescribing and MTMS on quality of care and dispensing costs, it is recommended that the impact of these changes be thoroughly studied and the implications to total pharmacy reimbursement, quality of care, and access to services be considered.

Dispensing Cost Policy Recommendations:

- Determine impact of Federal pricing changes on Medicaid reimbursement.
- Determine impact of national changes to published prescription drug pricing, including but not limited to AWP and AMP.
- Monitor impact of MTMS programs on quality of care in both Medicare and Medicaid programs for potential changes to Kansas Medicaid.
- Pilot MTMS in Kansas Medicaid, funded by CMS transformation grant. If not funded by CMS transformation grant, consider funding through Kansas Medicaid (with federal matching funds).
- Bring together pharmacy stakeholders to gather information and evaluate the impact of pharmacy pricing changes on reimbursement methodologies and access, especially in rural counties.
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